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ABSTRACT

This paper discusses the effects of and the need for training of parents of disturbed children. The authors have trained over 1200 parents in 68 parent training courses. They have offered 16 different types of programs to the parents of hyperactive, learning disabled, autistic or otherwise behavior-disordered children ranging in age from preschoolers to adolescents. They discuss briefly some of the programs offered, such as PAT (Parents Are Teachers) and PET (Parent Effectiveness Training). They conclude that parent training is a viable field, but that it needs to be studied and researched much more thoroughly in the future. (PPS)

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TEACHING BEHAVIOR MANAGEMENT SKILLS TO PARENTS: THE GROUP APPROACH

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It would be legitimate, perhaps even expected, for this audience to be wondering why two clinical psychologists from a state children's psychiatric hospital are here today discussing parent training. The reason quite simply is that we have trained over twelve hundred parents in sixty-eight parent training courses over the past six years. In that time we have offered sixteen different types of programs to parents of hyperactive, learning disabled, autistic and otherwise behavior-disordered children ranging in age from preschoolers through adolescents. Why this happened, how this happened, what we do, and what we have learned is why we are here today.

Traditionally, the state hospital serves as a repository for the most disturbed, least intact children - children whose families can no longer cope with them - children who must be separated from their parents and treated away from the very environment from which they came and to which it is hoped they will eventually return. Sagamore Children's Center was no different than this when it opened its doors seven and one-half years ago. It was the first children's psychiatric hospital of its kind in New York. Located on Long Island twenty-five miles from New York City, it was designed to be a modern, progressive inpatient facility for children. And when I arrived, my job was to help to upgrade inpatient care. I was hired some three months after Sagamore opened, as a fresh doctoral candidate from Stony Brook ready to cure the world with something called behavior

modification. My initial assignment was to organize the ward of severely acting-out adolescent girls. Of course, this was no simple task, but suffice it to say, that eventually thanks to the "miracle of behavior modification," specifically the token economy, within one year we had built a highly successful ward program - our patients were well behaved and they were happy, our staff was well trained and they enjoyed their work. We thought we had done it all.

But then, strange things began to happen. One day, the team social worker and I were visiting one of our children who had gone on a home visit. We had been prepared to impress upon this youngster's mother how well she had been doing. To do this we brought a variety of our charts and graphs with us to offer proof to this parent that her child indeed had done 97.2% of those things asked of her during the previous week and therefore had earned a virtual sea of special privileges. But rather than a smiling, grateful parent, we were faced with an angry, hostile, cursing mother who denounced us as phonies while at the same time slamming the door in our faces. As we stood on her doorstep bewildered, she continued to shout, and we were able to discern that her daughter was behaving as miserably at home as ever, fighting with her sister and not listening at all to her mother. Our first response to this was one of disbelief, we said, "This mother must be wrong, she herself must be crazy, or at least out of contact with reality."

Unfortunately, however, this scene was repeated in various forms over the ensuing weeks and months. Children whose behavior was exceptional in our hospital environment was frequently reported to be less

so on home visits. Furthermore, youngsters who had been near perfect in stays with us after years of misbehavior at home, would revert to previous behavior patterns within weeks of returning to their parents. While our first response to this situation was defensiveness and puzzlement, we began to realize the basic flaws in our strategy. We had successfully built an effective rewarding pro-social but artificial environment for our girls, but we had done nothing to extend our changes into the natural environment from which they came.

We decided that the next step must be to educate the parents and to teach them these things we had taught our staff — to apply social reinforcement principles in their own homes. So we began to invite parents to meet with us for this purpose. The typical scenario involved a session where we would begin addressing ourselves to a particular topic such as the effective use of praise and maybe five minutes or so into the discussion the parents would stop us and say - "Dr. Kaufman, what you are saying makes a lot of sense - BUT - can I ask you something, what do I do when Mary and her brother Billy argue about what TV program to watch and they start screaming and yelling? Those kids are driving me nuts with their fighting. In fact, unless you help us solve this problem, I don't see how we can take Mary home this weekend!" Of course, at this point we were trapped. We would go on to try to solve this specific problem as quickly as possible. And you can imagine how difficult this was. We would suggest solutions, and the parents would undoubtedly tell us they had tried this one or that one and it had not worked. So we

would make further suggestions and keep at it until finally an acceptable solution would emerge - but, by the time it did, our allotted time for the session would be up. And so, we would close the session by promising to begin anew during the following session next week.

That next session would begin with the parents thanking us for our helpful suggestions of the previous week, thus reinforcing our off-task efforts. We would be flattered but still we would attempt to push on with our more didactic approach. However, too often the pattern was set. Parents wouldn't let us continue; they would present another problem, let's call this problem A, and we would suggest various solutions, let's call them solutions X,Y, and Z, and then eventually after some debate we'd hit upon an acceptable one. But then parents would bring up problem B, and more solutions would be discussed, and so on, until after a few weeks, most of the problems would appear to be solved. At this point parents would say they were ready to take their children home and since there were no longer pressing concerns, they seemed to lose interest in pursuing our original intention.

At first we were somewhat encouraged by this individualized approach. In fact, it would have been acceptable to us, but we found that its effects were short lived. In these families too, we frequently found the pattern of new problems appearing just a few weeks or months after our sessions had ended. We found ourselves getting frequent phone calls asking us again to intervene using our A,B,C - X,Y,Z problem solving approach.

We realized that we had taught the parents little more than to be dependent upon us for solutions and that this dependency was mutually reinforcing - the parents appreciated our advice, and we enjoyed the feeling of seeing the successful application of our suggestions, but we had still not achieved our original goal of making the parents more prepared for their roles of raising behavior-disordered children.

So, in October, 1971, we switched approaches again. We organized our first parent training group. We sent advertisements and notices home to all the parents of the inpatients. Twenty-one parents of these children enrolled for our course which was taught using Becker's Parents are Teachers (1971) model. This course was less than a smashing success. Of the twenty-one parents who originally enrolled in this program, only three finished, and even they probably had limited success. But for us it provided a new direction and the start towards the development of our extensive parent training program. Since that time we have offered sixteen different types of parent-training programs, sixty-eight courses in all with a total enrollment of one thousand, two hundred and forty-two people.

All of our courses follow the same basic educational format. Parents usually meet weekly for sessions lasting two to three hours over the course of approximately ten weeks. Classes usually consist of lectures, discussions, and role playing. Both readings and written homework assignments as well as actual behavior-change projects are regular features. In some courses quizzes and homework are used to supplement the discussion. In all programs, our aim is to provide

parents with a framework for understanding their child's behavior and for solving problems as they arise. Classroom time in each session is spent discussing general principles and parents are encouraged to discuss the child's behavior only in this context. Parents are not encouraged to present the group with particular problems that they are facing with their own children, especially in early sessions of a given course. In later sessions the emphasis does change somewhat to individualization, but even here, we concentrate on discussing what the parent has already done to solve the problem and encourage the parent to attempt to develop new solutions by themselves. Our guiding principle is that the parent knows the situation and the child best and that if taught to, the parent can conduct sufficient assessment to effect a solution to the problem at hand. Our job is to provide the tools, the parents' job is to build the solutions from these tools.

We have few requirements for our courses other than parents' motivation. All programs are open to the general public as well as the parents of the parents of the children who are in Sagamore's regular inpatient or outpatient programs. Courses are regularly announced in flyers, newspapers, and radio spots and through parent organizations of special schools in the Long Island area. To enroll, parents need only send a brief application. There is no charge for any course other than a nominal materials fee ranging from $5 to $20 per family which covers books and coffee. Fees are waived if families cannot afford even this small amount.

Currently we are offering seven different parent training programs

at Sagamore Children's Center. Our Parents are Teachers course, known as PAT, is our most basic program. In it, we teach parents to apply behavior modification skills. There is a heavy emphasis on social reinforcement and positive contingency managment. We de-emphasize the use of punishment techniques and urge extreme caution in recommending the use of token programs. We suggest that the most natural interventions are the best, and in fact, we have found that most parents report success simply by increasing their use of praise. In addition to the standard PAT program, there is a preschool version and still another version for parents of hyperactive children. These two courses are similar in context to the original behavior modification course, but differ in that they are aimed at a more homogeneous group of parents. This enables us to spend more classtime giving examples for either the specific age group or behavior problem type under consideration. Furthermore, it enables us to deal with topics of special interest to these groups such as the Feingold Diet, stimulant medication, toilet training, etc.

In addition to these courses we regularly offer Parent Effectiveness Training in its original form as developed by Thomas Gordon. Our research shows that it is quite effective and we frequently suggest that parents take both PET and PAT since we believe that the skills taught in both courses are complementary.

We offer an extensive program for parents of learning disabled children which combines the techniques of PAT, PET with information about learning diabilities into a program designed to increase the parents' understanding of their learning disabled child as well as

enabling better management of these youngsters' special problems at home. Furthermore, the parent is taught how to set up tutorial programs with their own children which our research has shown to have both direct and indirect therapeutic effects. Another program currently being offered at Sagamore Children's Center is designed for parents and their young adolescents. This workshop involves both the parents and children in separate groups working on problem-solving and communication skills. Toward the end of this program, the groups are combined and skills are practiced first with members of different families and then with the parents and their own adolescents meeting together in dyads and triads.

Perhaps our most intensive program is for parents of autistic children. In the past five years it has evolved into a year-long program which aims at teaching parents to become intimately and actively involved in their child's educational program. The parents are taught to conduct daily teaching sessions with their children at home. These sessions are planned in concert with their child's own classroom teacher. The program itself involves an extensive series of inhome and school visits. This program has generated numerous clinical and research findings, some of which will be reported in a symposium to be given later today.

Of course, each of the programs that I have mentioned thus far is routinely evaluated. Data is collected before and after each course begins as well as in follow-up questionnaires filled out months later. Data is collected both on child and parent behavior as well as on changes in parent attitudes. Some of this data will

be presented to you shortly. In addition to this qualitative analyses of our programs, many of the courses and workshops which I have described have been the subject of functional research, with group designs featuring appropriate no-treatment and placebo-contact comparison groups. Some of this data has been presented and will be presented at other points in this convention. Those interested in obtaining some of that research should write to us.

This concludes my description of the evolution of the parent training program at Sagamore Children's Center. In the second half of our presentation, we thought it would be helpful if we gave you a profile of some of the kinds of people who take our courses, the types of problems their children present, and the types of solutions they have used to deal with these problems. For this I would like to turn you over to Dr. Dennis Dubey, who is currently the Coordinator of the Behavior Management Unit, the parent training section at Sagamore Children's Center.

Over the past two years we have conducted approximately fifty courses and programs for parents of children with a variety of behavioral and educational difficulties. In order to draw some general conclusions about the work we have conducted, we selected a sample of twenty-four classes from our most popular programs, which are the workshop for parents of children with behavior problems, the workshop for parents of hyperactive children (both of which are behavior modification workshops) and the Parent Effectiveness Training workshop, which of course is part of a national network of PET training in communication skills. Our total sample for these analyses were 330

families (406 individuals counting both mothers and fathers). In addition, a sample of forty-four families from a controlled investigation we conducted last year (Dubey, Kaufman, & O'Leary, 1977) contributed additional data. At the outset, I must publicly thank Eva Feindler, Gloria Miller, and Peggy Malinowski, who literally spent weeks retrieving and coding the data for our analyses.

The first set of questions we sought to answer relate to the kinds of families who voluntarily enroll in parent training services. As mentioned previously, our programs are open to parents of inpatients and outpatients, community residents, and professionals. In our sample, 5% were families of our own inpatients, 20% were of outpatients, and 72% were community residents having no other formal relationship with our Center. The remaining 3% were professionals from our own and other agencies. It is important to emphasize right here the fact that 72% of our families have not been on a formal patient status with our Center. Many parents welcome the opportunity to enroll in a service without going through the extensive interviewing and evaluations of their children which are required for formal patient status. We believe strongly that this arrangement has led to the significant popularity of our service within our local community. Looking at how families came to us, we find approximately equal percentage coming from schools, previous enrollees, our own Center, other professional agencies, and the media.

In looking at specific characteristics of our families, we have collected Hollingshead socio-economic data only on a special sample of forty-four families. In this sample, the mean Hollingshead score was

approximately 34, with a distribution scattered throughout the class levels. In fact this figure is undoubtedly higher than it would be on our total sample, as this sample were all recruited through the media and did not include any inpatients or outpatients of our Center. Since mothers were our primary data source, we did collect some descriptive information on them in our larger sample. The mean age of our mothers was 33 years. Approximately 25% were working mothers. Educationally, 20% had achieved a bachelor's degree or better and 28% had attended college for a limited time. Forty-three percent had completed high school only, and 5% had never finished high school.

Looking at some characteristics of the children, because of whom the parents were taking our courses, we find the mean age to be 8½ years. Nearly 75% of the children fall between the ages of 5 and 11, corresponding exactly with elementary school ages. In line with what we would expect, 82.5% of the children were male and only 17.5% were female. In looking at the male/female differentials by age, we find the largest discrepancy in the age 4 to 9 bracket. In other words, before age 4 and after age 9, the male/female ratio more closely approaches 1 to 1.

We next looked at the kinds of problems exhibited by the children whose parents sought our help. Whenever parents enrolled in a program, they were asked to list up to 5 specific problems they were having with their children. We have rated 1,340 presenting problems into fifteen categories, with a breakdown as follows: the most frequent problems were those which could generally be labelled

"disobedience," accounting for 11% of the total problems. Essentially, parents are saying that they want their children to be responsive to their wishes. "Fighting and teasing" accounted for 9% of the total problems; however, when we analyzed only the first problem listed by the parents, "fighting and teasing" was listed 20% of the time, indicating that these problems seem to have the highest priorities. Next in the ranking, with 8.7%, was a category we called "inappropriate verbalizations," including such problems as talking nasty and cursing. School problems fell right behind with 8.5% of the total. Hyperactivity followed with 7.3%, and then tantrums, poor peer relations, and "overemotional reactions" all came in with about 5% of the total each. We had a large block of unratable problems (26%) and then the others were spread out evenly among the remaining categories.

In looking at the distribution of problems by sex, males clearly showed a greater percentage of tantrums, fighting and hyperactivity. Females demonstrated greater percentages of peer problems and "bad habits," such as thumbsucking and nail-biting. Over the remaining categories, the percentages were relatively equal across the sexes, including the major areas of disobedience and school problems.

We also examined the distribution of problems by age for the 3-13 age range. Many of the problems were relatively evenly distributed, with a few exceptions. For example, the percentage of tantrums hovered around the 5% mark for all ages but 12 and 13, where it was about 13%. General disobedience was generally in the 10% range, except at age 3, where it rose sharply to 24%. In fact, at age 3, tantrums,

disobedience, and fighting accounted for over 40% of the problems, suggesting that our three year old were carrying their "terrible two's" at least an extra year. Hyperactivity was highest in the 4-7 year old range, and accounted for nearly 20% of the problems at age 4. The rest of the distributions are either equal or fail to fall into identifiable patterns.

I should mention also that the problem identified by the parents were of considerable severity. In fact, 85% of the families in our program had sought direct services for their children in the past.

Now that we have identified the kinds of families who attend parent-training programs and the kinds of problems they are seeking to remediate, the next set of questions revolves around our own efforts to help these families. How successful have we been? To determine this on an ongoing basis, we have routinely assessed change in the areas of 1) severity of the children's behavior problems; 2) hyperactivity ratings (in the case of our Hyperactivity Workshop participants); 3) parents' knowledge of child management skills; and 4) parental attitudes toward child rearing.

To measure severity, parents rated each of the five problems they identified on a Likert scale of severity both immediately prior to and immediately following their participation in the program. Ratings were averaged across the five problems to determine a single score for each child. The pre-post scores were analyzed individually by *t*-tests for each of 27 parent classes providing this data. Out of these 27 classes, 21 of them resulted in statistically significant reductions in problem severity ($p<.05$). Of the six classes failing

to yield significant results, three of these had N's of only three providing this data, making statistical significance difficult to reach. The three remaining classes all did approach significance ($p<.09$, $p<.15$, $p<.10$). Clearly, there is no question that parents are effecting significant reductions on problem behavior as a result of our courses. Incidentally, we also looked at the relative improvement of problems across problem categories. In this analysis, all problems improved about equally as well on our improvement scale, falling somewhere between "much improved" and "somewhat improved" with the exception of "bad habits" which fell midway between "somewhat improved" and "unchanged."

In our Hyperactivity Workshop we measured parents' ratings of hyperactivity through the Werry-Weiss-Peters Activity Scale (Werry, 1968), which assesses the severity and scope of hyperactivity. Pre-post scores were analyzed individually by t-tests for each of ten hyperactivity workshops. Out of these ten classes, eight of them resulted in statistically significant reductions in level of hyperactivity ($p<.05$).

In all of our behavior modification classes, we assessed parents' knowledge of behavior management skills by having them complete alternate forms of a Behavioral Vignette Tests before and after the workshop. The BVT provides sixteen questions about management or child management situations in which the parent must choose the most appropriate techniques. Among twelve classes administered the BVT, parents in ten of these classes made significant gains in their knowledge of management skills ($p<.05$). As

before, the two classes not reaching significance had very small N's providing outcome data.

Our final primary outcome measure was the Parent Attitude Survey (Hereford, 1963), a 75-item questionnaire designed specifically to assess parental attitudes toward child-rearing. On this measure, we have identified one relatively consistent finding that parents demonstrate significance increases in their confidence toward their parenting function. Of fifteen classes using the PAS, eight of them demonstrated significant gains in confidence at the .05 level, with an additional three classes falling within the .10 level.

To summarize up to this point, our parent education classes in child management have resulted in significant reductions in children's behavior problems, significant reductions in levels of hyperactivity, significant increases in knowledge of behavior management principles on the part of the parents, and significant increases in confidence of those parents.

Given that we had been finding our program to be generally effective, we were also interested in what the parents were actually doing when they left our Center and went back to their children. In other words, which of the various techniques we were teaching were the parents actually utilizing? We also had more than just a curious interest in this issue, as many persons have shown a serious concern about the widespread dissemination of behavior-control techniques such as we teach in our behavior modification programs. To determine the interventions employed

by the parents, we simply asked them to specifically identify how they attempted to solve each problem they had identified. We then coded the intervention techniques into twenty-two individual intervention categories. Some of the related categories were then combined to provide less confusing results. In total, we were able to gather intervention ratings on 410 individual problems.

Out of the 410 intervention ratings specified by parents, the most frequent category was simple praise for appropriate behavior. Praise was identified as the intervention technique slightly over 30% of the time. In general, positive means of influence involving praise, token systems, activity reinforcers and other, unspecified reinforcers comprised nearly 50% of the total number of interventions. Punishment techniques, including such things as loss of privileges, threats, and time-out, accounted for only 12% of the interventions. Ignoring inappropriate and attention-seeking behavior accounted for 15% of the strategies, while another 15% consisted of direct instructions or explanations.

Needless to say, the relative percentage of intervention strategies employed by the parents generally matches the emphasis we give them within the program. We consistently advocate the use of praise for appropriate behaviors to deal with many problems, and parents appear to have grasped this notion well. Although we teach parents how to set up token reinforcement systems, we are quick to point out the complications that can arise, and

thus tokens comprised only 9% of the interventions used. Similarly, we somewhat hesitantly teach parents how to use time-out situations in an effective manner, and we are glad to see time-out used only 5% of the time. Overall, it appears that parents can successfully reduce the severity of most of their children's behavior problems through the use of positive reinforcers, direct instructions, and ignoring of inappropriate behavior.

Finally, one of our primary concerns of course has been the long-term maintenance of the effects of our workshop. As we stated earlier, a major part of the rationale for conducting our program in this format has been our belief that permanent changes in parenting styles can be obtained as a result of parent education, and that permanent changes in the childrens behavior will be a consequence. In order to evaluate the permanence of our effects, we have sought to assess the levels of the gains made during the workshop at a six to nine month follow-up. Before presenting the data, it is important to note that our conclusions are based upon a limited amount of follow-up data, and that they suffer from all the limitations of data collected from less-than-the-original sample. In other words, we cannot say what happened within those families who failed to provide us with follow-up evaluations. Nonetheless, the data we do have looks very promising. On a sample of 51 parents, we have follow-up ratings on the severity of the original problems indicated when they took our course. The pre-treatment to follow-up reduction in severity is statistically significant ($p<.05$), dropping from a mean rating of

4.22 to a mean of 2.72 on the five-point scale. On the Werry-Weiss-Peters, a sample of 19 Hyperactivity Workshop participants indicates a mean reduction from 24.95 at pre-treatment to 14.32 at follow-up, again statistically significant ($p < .05$). On the BVT, the test of behavioral knowledge, our sample of 38 shows a significant mean increase from 7.05 to 10.11. Finally, on our attitudinal measure of confidence, a sample of 51 parents demonstrates a significant mean gain from 0.31 at pre-treatment to 6.25 at follow-up. In short, from the data we could collect, the gains made by the parents while they were in our programs appear to be relatively permanent.

Our final task is to attempt to draw some conclusions from both our hard data and our clinical experience regarding the solidification and future of parent-training as a continuing field. We feel there is little question that this is a viable field, one that is important to the future of parents and their children, and one that is still in a stage of infancy. We know that parent-training works; we hope that it is long-lasting. But we need to know a lot more. For whom does it work and for whom does it not work? Our preliminary attempts at prediction through such variables as social class, age and sex of child, type of problem, and inpatient vs. outpatient vs. community status have yielded no significant correlations. Yet we know that some people withdraw from training, and some stay but still fail. Parent training as we have utilized it can service large numbers of people. We need to know which will succeed in that relatively

less personal format and which will need the more individualized approach. Also, we should note that parent-training is many things - there are a number of distinctly different things being taught to parents within the realm of child management. We ourselves have conducted one investigation of the relative effects of behavioral and communications approaches. This type of evaluation, however, is relatively scarce at this point in time. And finally, we need to know what is really happening to those parents who participate in these programs. How do they interpret our techniques when they get home and are in the heat of "battle?" Clearly, we have a long way to go. Hopefully, a symposium such as this one will help be an impetus.

PERCENTAGE OF CHILDREN AT EACH AGE

AGE	PERCENT
1	.3%
2	1.5%
3	3.7%
4	2.8%
5	9.8%
6	11.7%
7	10.8%
8	12.0%
9	9.8%
10	10.5%
11	8.9%
12	5.8%
13	6.8%
14	2.2%
15	.6%
16	1.8%
17	.3%
18	.3%
19	.3%

MALE/FEMALE RATIO BY AGE

AGE	MALE/FEMALE RATIO
2	4:1
3	2:1
4	8:1
5	7:1
6	5.3:1
7	16.5:1
8	5.5:1
9	7:1
10	3.3:1
11	4.8:1
12	1.7:1
13	4.5:1
14	.75:1
15	1:1
16	5:1

PERCENTAGE OF PROBLEMS IN EACH PROBLEM CATEGORY

PROBLEM	PERCENT
Tantrums	5.7%
Disobedience	11.0%
Fighting and Teasing	9.0%
Hyperactivity	7.3%
Toileting	7.2%
Peer Relations	4.9%
Habits	2.1%
Inappropriate Verbalizations	8.7%
Steals/lies	2.7%
Eating	1.7%
School	8.5%
Neat and Clean	1.7%
Family Relations	3.4%
Overemotional	4.7%
Miscellaneous	26.4%

PERCENTAGE OF PROBLEMS IN EACH PROBLEM CATEGORY FOR MALES AND FEMALES

PROBLEM	FEMALE	MALE
Tantrums	2.7%	6.4%
Disobedience	11.1%	11.0%
Fighting & Teasing	6.2%	9.5%
Hyperactivity	4.9%	7.9%
Toileting	1.8%	2.3%
Peer Relations	6.7%	4.5%
Habits	4.0%	1.7%
Inappropriate Verbal	9.8%	8.4%
Steals/Lies	1.3%	2.9%
Eating	1.8%	1.7%
School	8.9%	8.5%
Neat and Clean	1.3%	1.8%
Family Relations	4.9%	3.1%
Overemotional	5.8%	4.4%
Miscellaneous	28.9%	25.9%

RELATIVE PERCENTAGES OF VARIOUS INTERVENTION METHODS

METHOD	PERCENTAGE
Praise	30.7%
Token System	9.3%
Activity Reinforcers	3.2%
Unspecified Reinforcers	5.4%
Time-Out	5.6%
Fines	1.2%
Threats	1.0%
Overcorrection	.7%
Loss of Privileges	.7%
Spanking	.5%
Yelling	.5%
Criticism	.2%
Unspecified Punishment	1.2%
Explain/Instruct	14.9%
Ignore	15.4%
Mutual Problem-Solve	.2%
Model	.2%
Parent Disowns Problem	1.5%
Miscellaneous	7.6%